



Martin O'Malley, Governor  
Anthony G. Brown, Lt. Governor  
John M. Colmers, Secretary

## Electronic Newsletter

Spring 2007

The Perinatal Network News is a publication of the Department of Health and Mental Hygiene's (DHMH) Center for Maternal and Child Health (CMCH). It is funded through a Crenshaw Perinatal Health Initiative grant provided to the Montgomery County Health Department.

The publication is intended as a communication tool for sharing perinatal information for a statewide audience, with information and resources that address statewide issues. It is designed as a vehicle to encourage collaboration and networking throughout the state. The newsletter provides an opportunity to share information on preconception and perinatal health issues and priorities, infant morbidity and mortality, county statistical trends and perinatal and child health indicators. It is an opportunity for local programs to share their strengths and insights as well as opportunities to ask for feedback and assistance in solving a local problem.

To ensure that this newsletter is a success, we need and encourage your participation. Please let us know of any items you would like to contribute, if you have suggestions for topics or areas you would like to see covered, or if you see that incorrect information was provided or that important information was inadvertently left out.

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# Perinatal network

Maryland Department of Health and Mental Hygiene

## Amended HIV Testing Bill Passed by the Maryland General Assembly

*Pamela Metz Kasemeyer, Esq., Schwartz and Metz, P.A., Counsel to MedChi, The Maryland State Medical Society; Maryland Chapter of the American Academy of Pediatrics; Maryland OB/GYN Society; Mid-Atlantic Association of Community Health Centers.*

In September 2006, the Centers for Disease Control and Prevention (CDC) issued new guidelines on HIV testing. The new guidelines are very comprehensive and make a number of significant recommendations regarding separate, written consent for testing, prevention counseling, routine HIV testing, and other issues relative to the elimination of barriers to testing and the expansion of HIV testing to a broader population. The recommendations are a call to place HIV testing in the same posture as other diagnostic testing with respect to consent, protocols, etc.

The issuance of the new guidelines provided an opportunity for Maryland and other states to revisit and revise their statutory and regulatory framework relative to HIV testing. The guidelines have produced a great deal of debate amongst stakeholders, most notably the advocacy community. The recommendations to eliminate the requirements for written informed consent and prevention counseling, and to incorporate HIV testing into the consent provided for general medical care and other diagnostic testing have not been uniformly embraced.

The provider community generally views the new guidelines in a very positive manner and believes, if the recommendations are adopted, most of the barriers to effective and broad-based testing will be eliminated. The advocacy community has been much more divided in their response to the CDC recommendations.

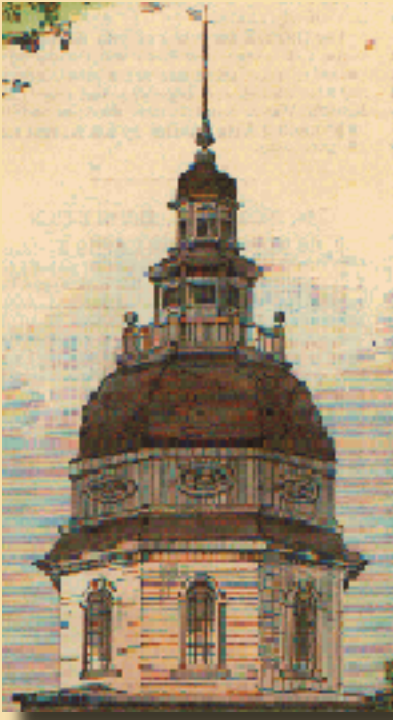
To that end, two different legislative proposals were introduced in the 2007 Session of the Maryland General Assembly to address issues regarding written informed consent and pre- and post-test counseling. Senate Bill 819 proposed to eliminate written informed consent and the separate distinct consent form. Further, the bill called for the AIDS Administration to convene a workgroup of stakeholders to review the balance of the CDC guidelines and report on recommended statutory changes before the 2008 legislative session. The advocacy community was split in its support for the elimination of written informed consent.

*continued p.2*

Senate Bill 749/House Bill 781 was also introduced and proposed eliminating the separate HIV consent form required by the Maryland Department of Health and Mental Hygiene, but still requiring written informed consent that is separate and distinct from the consent used for other tests or medical care. It called for a workgroup to be convened to study how to streamline pre- and post-test counseling requirements and to report back before the next legislative session. The proponents of Senate Bill 819 did not believe the elimination of the HIV consent form, without the elimination of the requirement for separate written informed consent, advanced the elimination of testing barriers and therefore did not support Senate Bill 749/House Bill 781.

As a result of the differences of opinion amongst stakeholders on how to proceed with consideration and implementation of the new CDC guidelines, as well as the AIDS Administration's appropriate focus on passage of the HIV name-based reporting legislation, the General Assembly chose to pass an amended version of Senate Bill 749/House Bill 781. The legislation that was enacted requires the AIDS administration to convene relevant stakeholders to review the CDC guidelines, specifically as they relate to consent and pre/post test counseling, and to report back on recommended statutory changes before the 2008 General Assembly convenes. The bill must be signed into law by the Governor before May 31st, an action that is anticipated without controversy.

It is expected that the work of the stakeholder group will begin sometime this summer and continue through the fall. The AIDS Administration will undoubtedly advise stakeholders on how they wish to proceed. The guideline review will provide an excellent and unique opportunity to identify how Maryland can update its HIV testing requirements in order to eliminate barriers to testing, facilitate early identification and treatment, reduce transmission and enhance the quality of life for those who are HIV positive.



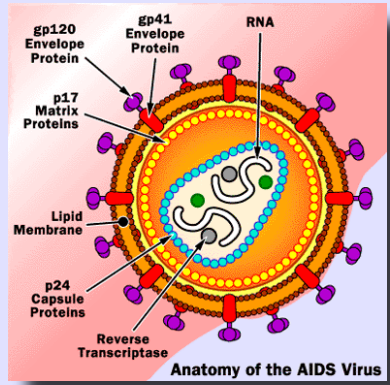
## Maryland HIV/AIDS Reporting Bill Passed by the 2007 General Assembly

*Colin P. Flynn, Chief, Center for Surveillance and Epidemiology, AIDS Administration, Department of Health and Mental Hygiene*

On Friday, April 6, 2007, the Maryland General Assembly passed the Maryland HIV/AIDS Reporting Act. The legislation is expected to go into effect immediately after being signed by Governor O'Malley. The new law will require physicians to begin reporting HIV cases, by name, to the health department. This is in addition to the current requirement for physicians to report AIDS cases by name. It will also require physicians to report infants who are born to HIV-infected mothers. Reporting of HIV cases and of exposed infants will be done using the Maryland Confidential Morbidity Report (DHMH-1140) form used for all communicable disease reporting.

The passage of the Maryland HIV/AIDS Reporting Act will facilitate the transition from code to name-based HIV reporting in compliance with the new federal mandate. This legislation allows the Department of Health and Mental Hygiene's AIDS Administration to take the necessary steps to ensure that Maryland will continue to be eligible to receive federal funds for HIV/AIDS services through the Ryan White Treatment Modernization Act of 2006.

For up to date information about the status of the new reporting law and, after the law is in effect, for information about how to report, including copies of the revised Morbidity Report form, please visit: <http://dhmh.state.md.us/AIDS/HivReporting/HivReport.html>.



### Maryland AIDS Administration Reporting Web Site

At this Web site you will find links to resources that will help explain not only why this transition to a name-based reporting system is necessary to preserve the State's federal funding, but how this transition will affect providers and community members, and how Maryland uses HIV/AIDS information.

Visit: <http://dhmh.state.md.us/AIDS/HivReporting/HivReport.html>

## Methamphetamine Added to Definition of Drug-Exposed Infant

*Charlie Cooper, Administrator, Maryland Citizens Review Board for Children*

House Bill 340/Senate Bill 686 was enacted by the Maryland General Assembly and signed into law by Governor Martin O'Malley. This bill expands the definition of drug-exposed infant to include exposure to methamphetamines, as well as currently listed cocaine and heroin that can enable special protections for a newborn infant. The definition of drug-exposed infant can trigger a petition for guardianship or a Child In Need of Assistance (CINA) proceeding.

Exposure to any of these three drugs as evidenced by a positive test on the mother or the infant can trigger a report to a local department of social services by the hospital, if the hospital feels that the child's safety or well-being is at risk. If the mother refuses drug treatment or fails to comply after enrollment in a drug treatment program, authorities can remove the child and custody may be given to social services.





# All U.S. States To Begin Name-Based Reporting of HIV Cases by End of 2007

All U.S. states and Washington, D.C., by the end of 2007 will begin recording HIV cases using name-based reporting systems rather than code-based reporting systems, the AP/Springfield State Journal Register reports. Beginning this fiscal year, the funding formulas used by HHS to calculate Ryan White Program grants include only HIV data from states that use name-based reporting systems, the AP/Journal Register reports. Vermont, Maryland and Hawaii are the only states not currently using a name-based reporting system to track HIV cases. In 1999 CDC endorsed name-based reporting and in 2005 recommended that states use name-based reporting systems. Timothy Mastro, deputy director of CDC's Division for HIV/AIDS Prevention, said, "After many evaluations of code-based systems, it became clear that those systems do not meet CDC standards for HIV data." He added that syphilis, tuberculosis, and AIDS cases are tracked by name-based systems.

## Advocates' Concerns

Many HIV/AIDS advocates are concerned that the transition to a name-based system will discourage some people from seeking HIV tests or treatment, the AP/Journal Register reports. "I've not so much changed my opinion as surrendered," Ron Johnson, Deputy Executive Director of Aids Action in Washington, D.C. said, adding, "I still believe code-based reporting is valid and is preferable for HIV reporting. It, for all practical purposes, has become a losing battle." Some advocates also are concerned that security breaches could lead to the names of HIV-positive people being released. A 2005 security breach in Palm Beach County, Florida, involved the names of 6,500 HIV-positive people being erroneously e-mailed to 800 county health workers. Similar security breaches have occurred in California and Kentucky, the AP/Journal Register reports. In addition, some advocates are worried that a name-based system would reduce the number of minorities and low-income people who receive HIV tests because they might be less likely to trust that the government would keep their names confidential. Catherine Hanssens of the New York City-based Center for HIV Law and Policy said that name-based reporting "can affect if (disadvantaged) people come back for care" and "how they describe to other people their experience of getting tested." According to the AP/Journal Register, some physicians are telling HIV-positive people to use false names, but health officials say it is impossible to determine how many physicians and patients are not reporting their names. Health officials also say it will be impossible to determine whether any decline in HIV cases can be connected to name-based reporting. New HIV cases in Illinois decreased by 14 percent from 2005, the last year code-based reporting was used, to 2006, although there had been an 8 percent decrease in new HIV cases in 2005.

## State Efforts To Protect Privacy

William Wong, Medical Director of the AIDS division of the Chicago Department of Public Health, said the state's old code-based system, which assigned HIV-positive people a unique identification code, was "instituted to protect the people's confidentiality because of fears of stigmatization and potential disclosure to insurance companies and family members." In 2006, the state began using a name-based system. Under the new system, staff members who have access to the database must take an oath of confidentiality and undergo special training. The names also are stored on a stand-alone computer system that is in a locked area, according to the AP/Journal Register. A Vermont bill (SB 192) prohibits the storage or processing of any information that could identify HIV-positive people on network computers or laptops. The bill also allows civil lawsuits for malicious disclosure of such information, according to the AP/Journal Register (Johnson, AP/Springfield State Journal Register, 4/2).

*Reprinted with permission from the Kaiser Daily Health Report.*



# SIDS Continuing Education Program Developed by NICHD

*Hanan Kallash, MS, National SIDS/ID Program Support Center*

The National Institute of Child Health and Human Development (NICHD) and the National Institute of Nursing Research (NINR), in collaboration with First Candle/SIDS Alliance, and several national nursing organizations, have developed a nurse continuing education (CE) program on Sudden Infant Death Syndrome (SIDS) risk reduction and infant sleep safety. The goal of the program is to increase the capacity of nurses to educate families and caregivers about ways to reduce risk factors associated with SIDS.

The purpose of this CEU will be to share with nurses:

- ◆ the latest risk-reduction information on SIDS,
- ◆ increase their knowledge base and enhance their skills to communicate this information to parents and caregivers in a culturally competent manner by:
  - ◆ using scientific and evidence based research,
  - ◆ identifying a safe sleeping environment to lower the risk of SIDS, and
  - ◆ discussing common barriers and myths to complying with the SIDS risk reduction recommendations for nurses, parents, caregivers, and others.

The module has been well received and presented at numerous national, regional and local venues such as: Mercy Hospital Center of Excellence for Women's' Health Symposium, National Black Nurses Association Health Symposium, Baltimore City Community Colleges, National Perinatal Association, NY-NJ Regional Meeting, Wisconsin National Nursing Association, Mississippi National Nursing Association, Professional Nurse Educators Group Annual Meeting, National Association for Neonatal Nurses, American Academy of Nursing, National Alaska Native American Indian Nurses Association, Fletcher Allen Health Care System, and the Association of Maternal and Child Health Programs.

Over 400 nurses have completed the module nationwide and there are currently 5 more regional trainings and four national conferences scheduled, such as the American Academy of Nurse Practitioners Annual Conference, the American College Health Association, the South Carolina Public Health Association, West Virginal Health Department, and the Texas Perinatal Association.

For more information regarding the module and bringing the training to your organization, please contact Debra Howe or Kathleen Graham at 1-800-221-7437.

National Institute of Child Health and Human Development

Web site: <http://www.nichd.nih.gov/>

National Institute of Nursing Research

Web site: <http://www.ninr.nih.gov>

SIDS Alliance Web site:

<http://www.sidsalliance.org>

SIDS Mid-Atlantic

<http://www.sidsma.org/>





# Somerset County Health Department Receives Funding from Gannett Foundation for the Lower Shore Perinatal Council's Cribs For Kids Program

Charity Holley, MA, Director Health Promotion and Disease Prevention,  
Somerset County Health Department

The Lower Shore Perinatal Council presents Cribs for Kids (C4K), which is a call to action to enhance Sudden Infant Death Syndrome (SIDS) health education in the tri-county area of Somerset, Worcester, and Wicomico counties. The plan's objectives are rooted in Healthy People 2010 and follow the American Academy of Pediatrics 2000 guidelines, as well as baseline measures taken from data sources unique to Maryland and the tri-county area. The overarching goal of this plan is to significantly effect prenatal health education in regards to SIDS in the community healthcare setting.

The Lower Shore Perinatal Council's Cribs for Kids project targets at-risk populations in high-risk communities in Somerset, Worcester, and Wicomico County, Maryland. In 2003, the three counties located on the lower Eastern Shore of Maryland; Worcester, Wicomico and Somerset Counties shared the problem of a combined infant mortality rate greater than the state at a rate of 8.4 compared to 7.9 for Maryland. Education remains a crucial component of the Lower Shore Perinatal Council's mission.

The role of Sudden Infant Death Syndrome in our high-risk communities is important. SIDS is of particular public health concern because it can be reduced through safe sleeping practices for infants and education regarding cultural practices for specific infant care issues. Therefore, to address the major risk factor of the sleeping environment, the Lower Shore Perinatal Council presented the Cribs for Kids program in 2007 to avoid child deaths on the local level through public health intervention.

The Lower Shore Perinatal Council, through the leadership of the Somerset County Health Department, developed and implemented the Cribs for Kids project. The project is a new and innovative program, which after a comprehensive literature review regarding SIDS education, combines best practices from other states such as North Carolina and Pennsylvania. The project involves all three health departments in creating a new program to address the positive reinforcement of the 2000 American Academy of Pediatrics guidelines and the national Back to Sleep campaign.

The program was partially funded by the Gannett Foundation in 2007, allowing the three lower shore counties to distribute FREE pack-n-plays to individuals in need. To date, 134 pack-n-plays have been distributed in the tri-county area. The project's long-term impact for healthy babies in the tri-county area is huge. If the health departments can make a change in the appropriate bedding issue by lowering the rates and percentages of SIDS and SUDI deaths in Worcester, Wicomico and Somerset counties, the program will be considered a huge success.



# Baltimore City Healthy Start Launches Web Site

Dana Gaskins, Director of Health  
Education and Marketing, Baltimore City  
Healthy Start

Baltimore City Healthy Start is the premiere infant mortality reduction program operating for the past 16 years in desperate communities where clients live surrounded by poverty and poor health, their lives impacted daily by the domestic violence, substance abuse, an array of mental illnesses, and HIV/AIDS. Serving over 10,000 pregnant and postpartum women through the years, Healthy Start utilizes its unique home visiting approach to find and service its clients, including canvassing communities door-to-door, and in the community.

Once enrolled, clients receive intense case management that includes screenings for mental health and asthma, home safety and demographic assessments, submission of health insurance applications, educational assessments and social service needs assessments. Through a network of referrals, skilled case management, and outreach staff called Neighborhood Health Advocates, clients receive wrap-around services that include assistance with housing and utilities, and groups on parenting and healthy relationships. These staff are certified: phlebotomists, HIV testers and counselors, substance abuse counselors, and nursing assistants. In a philosophy to meet clients where they are, Healthy Start is an example of a well tested model for creating access for difficult-to-reach populations.

Also unique to Healthy Start is the family planning component whereby OB/GYN professionals and High Risk Nurse Specialists see clients in the home or in centers to provide testing and treatment for STD's and bacterial vaginosis, postpartum examinations, and family planning that includes education and the dispensing of contraception. These nurses are employed by Healthy Start and clients with and without medical insurance can be seen for no cost.

In 2006, Healthy Start undertook a feasibility study as a precursor to fundraising activities. That study substantiated the organization's need to increase its visibility to provide education on infant mortality to those affected by/or at risk for poor birth outcomes, as well as the broader community, and to engage possible donors. This was the impetus for Healthy Start to launch a web site in March 2007 at [www.baltimorehealthystart.org](http://www.baltimorehealthystart.org).

Since launching the site, Healthy Start has received numerous hits, e-mails and phone contacts. On the site, there is information on the history of Healthy Start, depression, and breastfeeding, as well as information on all funded operations. While this is a new venture for us that comes with the challenges of maintaining a live connection to so many of our partners and supporters, the time had come for this organization to utilize technology to reach and inform others on the critical issues surrounding infant deaths.

The site opens with testimonials from our clients and highlights our success stories as well. In the coming months, the site will add video news clips and PSA's featuring Healthy Start in action.

For more information, contact: Dana Gaskins, 410-396-7318.

Visit the web site at: [www.baltimorehealthystart.org](http://www.baltimorehealthystart.org).



## Programs and Services

Healthy Start services are offered through the child's second birthday. In order to build upon past efforts toward eliminating disparities in prenatal health, BCHSI offers a core set of outreach and case management services:

Healthy Start Program

Success By 6®

In Home/In Center Family Planning Program

Program Health Tests and Screenings

Breastfeeding Group

Mental Health Group

Healthy Relationship, Healthy Marriage Group

Early Childhood Development Program  
Home Visiting/Case Management





PREVENTION OF PERINATAL INFECTIONS  
The Baltimore Regional Perinatal Advisory Group

TIMING	PROCEDURE	INDICATION
1 <sup>ST</sup> PRENATAL VISIT	RPR/STS/VDRL	<b>REQUIRED</b> under Code of Maryland Regulations (COMAR 10.06.01.17) <sup>1</sup>
	HIV counseling/offer HIV testing	<b>REQUIRED</b> under Annotated Code of Maryland. Health-General Section 18-338.2
	HBsAg	RECOMMENDED <sup>1,2,3</sup>
	Rubella IgG antibody	RECOMMENDED <sup>3</sup>
	GC detection	RECOMMENDED <sup>1</sup>
	Chlamydia detection	RECOMMENDED <sup>1</sup>
	BV – Test or diagnose clinically	RECOMMENDED by some experts for pregnant women at risk for preterm labor <sup>1</sup>
	Pap	RECOMMENDED <sup>1,3</sup>
	Urine culture/screen	RECOMMENDED <sup>3</sup>
	Hepatitis C – Antibody screen	RECOMMENDED for women at risk for infection <sup>1</sup>
	Genital herpes - Elicit history for possible exposure	RECOMMENDED <sup>1</sup>
	Varicella – Determine immune status (history or lab)	RECOMMENDED <sup>3</sup>
28 WEEK VISIT (EARLY 3 <sup>RD</sup> TRIMESTER)	RPR/STS/VDRL	<b>REQUIRED</b> under COMAR 10.06.01.17
35-37 WEEK VISIT (LATE 3 <sup>RD</sup> TRIMESTER)	HIV counseling/HIV testing (preferably at < 36 weeks gestation)	RECOMMENDED for pregnant women in Maryland <sup>6</sup>
	GBS culture (rectovaginal)	Universal screening approach RECOMMENDED for all pregnant women <sup>3,4</sup>
	GC detection	RECOMMENDED again in the 3 <sup>rd</sup> trimester for women at high risk of infection <sup>1,3</sup>
	Chlamydia detection	RECOMMENDED again in the 3 <sup>rd</sup> trimester for women < 26 years of age, or women at high risk of infection <sup>1,3</sup>
	HBsAg	RECOMMENDED again in the 3 <sup>rd</sup> trimester for HBsAg-negative women at high risk of infection <sup>1,3</sup>
LABOR & DELIVERY	RPR/STS/VDRL	RECOMMENDED for all women at continued risk <sup>1</sup> <b>REQUIRED</b> in Baltimore City for all deliveries under Health Commissioner's Order and statewide under COMAR 10.06.01.17 for deliveries with no prenatal care
	HIV counseling/HIV rapid testing	RECOMMENDED for women not previously screened, or if status unknown/undocumented <sup>1,6</sup>
	HBsAg	RECOMMENDED for women not previously screened, or at high risk of infection, or if status unknown/undocumented <sup>1,2,3</sup>
	GBS - Treat if culture positive at 35-37 weeks; if status unknown, treat by risk-factor criteria	RECOMMENDED <sup>4,5</sup>
	Genital Herpes - Obtain history and examine genitalia for herpetic lesions	RECOMMENDED <sup>1,3</sup>

1      Guidelines for the Treatment of Sexually Transmitted Diseases 2006 (CDC, MMWR, August 4, 2006/Vol. 55/No. RR-11) for management of positive results. <http://www.cdc.gov/std/treatment/2006/toc.htm>, and for errata/critical updates: <http://www.cdc.gov/std/treatment>.

2      A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infections in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Part I: Immunization of Infants, Children, and Adolescents (CDC, MMWR, Dec. 23, 2005/Vol. 54/No. RR-16) for management of positive results. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5416a1.htm>.

3      Guidelines for Perinatal Care. American Academy of Pediatrics; American College of Obstetricians and Gynecologists. October 2002.

4      Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines from CDC (CDC, MMWR, Aug. 16, 2002/Vol. 51/RR-11) for management of positive results. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm>.

5      Prevention of Early-Onset Group B Streptococcal Disease in Newborns. ACOG Committee Opinion No. 279. American College of Obstetricians and Gynecologists. Obstetrics and Gynecology 2002;100:1405-12.

6      Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings (CDC, MMWR, Sep. 22, 2006/Vol. 55/No. RR-14) <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

For additional copies, call The Perinatal Infections Outreach Program, Baltimore County Department of Health, 410-887-3134, or go to: [www.baltimorecountymd.gov/go/perinatal](http://www.baltimorecountymd.gov/go/perinatal).

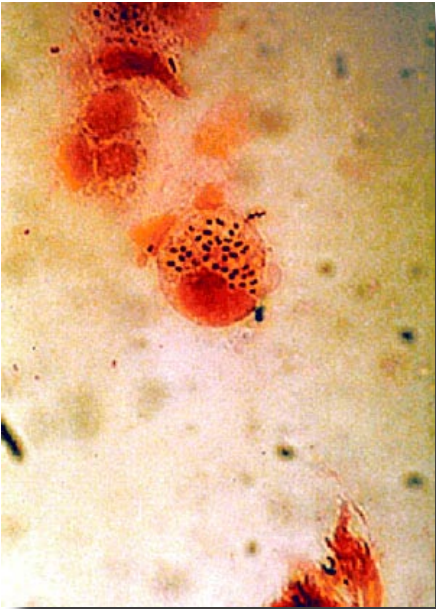
Fluoroquinolones No Longer Recommended  
for Treatment of Gonococcal Infections

In the United States, gonorrhea is the second most commonly reported notifiable disease, with 339,593 cases documented in 2005. Since 1993, fluoroquinolones (i.e., ciprofloxacin, ofloxacin, or levofloxacin) have been used frequently in the treatment of gonorrhea because of their high efficacy, ready availability, and convenience as a single-dose, oral therapy. However, prevalence of fluoroquinolone resistance in *Neisseria gonorrhoeae* has been increasing and is becoming widespread in the United States, necessitating changes in treatment regimens.

Beginning in 2000, fluoroquinolones were no longer recommended for gonorrhea treatment in persons who acquired their infections in Asia or the Pacific Islands (including Hawaii). In 2002, this recommendation was extended to California. In 2004, CDC recommended that fluoroquinolones not be used in the United States to treat gonorrhea in men who have sex with men (MSM). This report, based on data from the Gonococcal Isolate Surveillance Project (GISP), summarizes data on fluoroquinolone-resistant *N. gonorrhoeae* (QRNG) in heterosexual males and in MSM throughout the United States.

This report (Update to CDC's Sexually Transmitted Diseases Treatment Guidelines, 2006), also updates CDC's guidelines regarding the treatment of infections caused by *N. gonorrhoeae*. On the basis of the most recent evidence, CDC no longer recommends the use of fluoroquinolones for the treatment of gonococcal infections and associated conditions such as pelvic inflammatory disease (PID). Consequently, only one class of drugs, the cephalosporins, is still recommended and available for the treatment of gonorrhea.

“Update to CDC's Sexually Transmitted Diseases Treatment Guidelines, 2006”, available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5614a3.htm?>



HIV Prevention Reference Docs

The Baltimore Regional Perinatal Advisory Group (RPAG) has produced two documents that are being printed and laminated for inclusion in the next 500 Perinatal HIV Prevention Toolkits.

▼ The RPAG's "Prevention of Perinatal Infections" summarizes the latest screening recommendations for infections during pregnancy from the American College of Obstetricians and Gynecologists (ACOG), the Centers for Disease Control and Prevention (CDC), and the Code of Maryland Regulations. This document is reproduced on page 8 of the Perinatal Network.

This one-page sheet can be posted so it is readily available to professionals in your office, providing a quick and comprehensive reference. The RPAG developed this tool to address the problem of perinatal infections by providing reminders of both long-standing and recent recommendations for perinatal infectious disease screening.

▼ The "Summary of the 2006 CDC STD Treatment Guidelines" summarizes the latest recommendation of the CDC for the treatment and management of STDs. These guidelines are to be used for clinical guidance, and are not meant to be inflexible. This summary has been adapted with permission from the summary provided by the Region III STD/HIV Prevention Training Center.

For more information, contact Elisabeth Liebow, 410-887-3134, e-mail: [eliebow@baltimorecountymd.gov](mailto:eliebow@baltimorecountymd.gov)



# Healthy Babies Coalition

Peter Gelzinis, Administrative Specialist, Division of Health Information and Promotion, Anne Arundel County Department of Health

The Anne Arundel County Department of Health and the Healthy Babies Coalition have made much progress in addressing the problem of infant death in the African American community. Since the Healthy Babies Summit in August 2006, the Department of Health has been working with a coalition of approximately 50 stakeholders including Department employees, county residents, government officials, and representatives from healthcare and faith organizations. The Healthy Babies Coalition was assembled with the goal of pulling together community resources to develop and implement community health interventions designed to improve health disparities and decrease infant death in the African American community.

The Coalition, formed in late September 2006, is composed of an Executive Committee and three subcommittees: Community Education and Outreach, Race and Community Issues, and Access to Care and Provider Issues. Department of Health employees sit on these committees along with the representatives from various community and healthcare organizations.

In the months after the Coalition was formed, the subcommittees met to discuss what issues were most critical to them and how these issues might be addressed in the future. The topics that were identified and the solutions and interventions that were devised as a response to these problems were submitted to the Executive Committee for further review.

The Executive Committee synthesized the recommendations of the three subcommittees into a comprehensive plan for health intervention programs. Dr. Jinlene Chan, Physician Clinical Specialist for the Department of Health and a

member of the Executive Committee recalled, “There were disagreements in our Executive Committee meetings because we had people who represented different organizations whether healthcare, government, or community-based, but I think these different perspectives produced a more complete plan.” Michelle Hawkins, Director of Care Management for Johns Hopkins Healthcare and a member of the Coalition agreed, stating, “The only way this issue can be addressed and improved is through the collaborative effort of the Healthy Babies Coalition.” The implementation plan that was put together by the Executive Committee outlines key aspects such as purpose, objective, target audience, and method of evaluation of the several intervention programs. These intervention programs were developed with the vision statement of the Coalition in mind: All babies in Anne Arundel County are born healthy and thrive.

The other component of the implementation plan includes a multifaceted community health information campaign. The Department of Health partnered with Herrmann Advertising Design to develop a message that will be placed in community newspapers and aired on the radio around the County. Herrmann developed the ads after working with 15 African American women who voiced their opinions about appropriate messages and graphics that will resonate with other young African American women.

The Coalition Executive Committee, community members, and focus group participants identified a key statistic—the death rate for African American babies is three times higher than that of whites in Anne Arundel County as the focal point of the campaign. Members of all groups felt this statistic accurately captured the seriousness of the issue and would encourage young African American women to seek more information on having a healthy pregnancy and baby.

The Department of Health also formed a key partnership with the

Tot’s Line, a toll free phone number staffed by social workers and early childcare professionals who offer advice to families and caregivers in the County. The Tot’s Line is funded by the Anne Arundel County Local Management Board and operated by Family Tree, Maryland’s largest nonprofit organization dedicated to providing solutions to child abuse and neglect. The Local Management Board and Family Tree have agreed to allow the Tot’s Line to be used in the Healthy Babies information campaign. The Tot’s Line will serve as the point of contact for questions from pregnant women and new mothers. Healthy Pregnancy and Baby Care kits, both of which are stocked with information and resources for young pregnant women, will be mailed to those who call the Tot’s Line.

If you would like to learn more about the Healthy Babies Initiative, please contact Laurie Fetterman, M.S.W., Health Planner, Division of Health Information and Promotion, Anne Arundel County Department of Health at (410) 222-7203 or E-mail: [hdfett00@aacounty.org](mailto:hdfett00@aacounty.org).



# Maternal Race, Procedures, and Infant Birth-weight in Type 2 and Gestational Diabetes

## A Maryland Data Study Abstract

### Objective

To examine the relation between race and cesarean delivery, episiotomy, and low birth weight infants in pregnancies with type 2 and gestational diabetes mellitus, and to identify factors that might explain racial differences.

Methods: Population-based, cross-sectional study of 1999-2004 Maryland hospital discharge data. Hospitalizations for delivery of pregnancies with type 2 and gestational diabetes mellitus were identified and matched to infants. The independent variable was maternal race. Dependent variables were cesarean delivery, episiotomy, and low infant birth weight. Stepwise logistic regression models were developed to estimate the independent effect of race on use of each procedure and infant birth weight, after adjusting for sociodemographic, hospital, and clinical factors.

### Results

We examined 6,310 deliveries for pregnancies with type 2 (15 percent) and gestational (85 percent) diabetes. Before adjustment, black race was associated with a higher odds of cesarean delivery (odds ratio [OR] 1.40, 95 percent confidence interval [CI] 1.24-1.58) and low birth weight infants (OR 1.94, 95 percent CI 1.57-2.40) compared with white race. Adjustment for racial differences in preeclampsia and fetal heart rate abnormalities accounted for a modest degree of the racial variation in outcomes.

With full adjustment, black race was still associated with a higher odds of cesarean delivery (OR 1.38, 95 percent CI 1.20-1.60) and low birth weight (OR 1.81, 95 percent CI 1.41-2.34) and a lower odds of episiotomy (OR 0.45, 95 percent CI 0.36-0.57).

### Conclusion

In pregnancies with diabetes, adjustment for sociodemographic, hospital, and clinical factors only partially explains racial differences in procedure use and infant low birth weight.

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Source: *Obstetrics & Gynecology*. 108(3 Pt 1):626-34, 2006 Sep.



# Calendar Events

## Maryland FASD Meetings Dates

Thursday, August 16, 12:30 p.m.

Thursday, November 15, 12:30 p.m.

All of the meetings will be at Kennedy Krieger—Greenspring Ave. in Baltimore.

For more information, contact Mary Johnson 410-767-5581.

## June

### 2005 National HIV Prevention Conference

June 12-15, Hyatt Regency Atlanta Hotel.

The Centers for Disease Control and Prevention (CDC) joins other governmental and non-governmental prevention partners to announce the fourth conference highlighting HIV prevention in the United States. For information:

[www.2005hivprevconf.org/](http://www.2005hivprevconf.org/)

## July

23-26

SHIP —The Seventh Annual School Health Interdisciplinary Program, "Charting the Course for Our Children's Future!"

Turf Valley Resort and Conference Center, Ellicott City, Maryland

Hear nationally recognized speakers. Choose from seven tracks, such as: 1) Early Childhood, 2) Adolescent, 3) Mental Health, 4) Health Services and Health Education, 5) Family Involvement, 6) Violence, 7) Healthy School Environment; also participate in Workshops on:

Adolescent Health, Violence Prevention, Clinical Updates, Early Childhood, Nutrition, Family Involvement, Gang Awareness, HIV Prevention, Psychopharmacology Update, Suicide Prevention, Positive Youth Development and many others!

Plenary Day: \$150

One-Day Workshops: \$140

Full Week: \$350

For information about the conference, exhibit information, or to receive a brochure, please contact Christina Huntley at the Center for School Mental Health Analysis and Action (888-706-0980; 410-706-0980; [chuntley@psych.umaryland.edu](mailto:chuntley@psych.umaryland.edu)) or visit Web site: <http://csmha.umaryland.edu>

Early-Bird Special Rates: \$325 for Full Week.

25

Maryland Breastfeeding Coalition Meeting

9:30 a.m. Johns Hopkins—School of Nursing

## September

20

1st Annual Maryland FASD Conference: Call FASD Coordinator at 410-767-5581 for more details.

## October

24

Maryland Breastfeeding Coalition Meeting

9:30AM—Wyman Park Health Systems